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Attempts were made to discover whether the observable behavior symptoms of young children in the school setting, when measured by objective screening methods, will reflect families that have disordered behavior. The objectives included testing the validity of two Behavior Rating Scales, developing a single rating test, and analyzing the significant differences between the experimental and control families.

Results proved that a very significant proportion of young children with school problems reflects a family with problems. The screening technique developed is the 11-item Behavior Rating Scale.

Tables are included.

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EARLY IDENTIFICATION OF BEHAVIOR PROBLEM CHILDREN AND MULTI-PROBLEM FAMILIES

by

Paul T. Beisser

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January, 1962

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A RESEARCH STUDY

in

EARLY IDENTIFICATION

OF BEHAVIOR PROBLEM CHILDREN AND MULTI-PROBLEM FAMILIES

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Brisbane Elementary

Burlingame Elementary

Coastside Union Elementary

Jefferson Elementary

La Honda Elementary

Laguna Salada Union Elementary

Millbrae Elementary

Ravenswood City Elementary

Redwood City Elementary

San Bruno Park Elementary

San Mateo City Elementary

South San Francisco Unified

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The material in this report may be used freely provided that credit is given to the Office of the San Mateo County Superintendent of Schools. We would appreciate being informed of its use as a matter of record.

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I. INTRODUCTION

During the past half century this country has experienced the proliferation of community services, some specialized, some generalized, to deal with families and individuals having problems of social maladjustment with which they cannot cope. Traditionally, these casework, clinical, welfare and judicial services have dealt with the cases which applied for help, were referred, were complained about or were reported as law breakers. The service load thus acquired (as of a given month) amounts to between four and five percent of the community's families with children under eighteen years of age, as revealed by the Community Research Associates (N.Y.) prevalence studies in the demonstration projects in San Mateo County, California,[1] Winona County, Minnesota[2] and Washington County, Maryland.[3] This case load represents as much as seventy-five percent of the activity of these agencies.

Community planning for coordination of and more effective activity by these many separate agencies has been of little avail. Efforts at genuine prevention or reduction of the problems have been based largely on guesswork. Two basic difficulties have been present. There has been a lack of what the public health experts call "epidemiological data", knowledge of

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[1]Community Research Associates (N.Y.): "Reorganizing to Prevent and Control Disordered Behavior." Mental Hygiene, April, 1958.

[2]Community Research Associates (N.Y.): "Reorientation for Treatment and Control." Special Supplement of Public Welfare, April, 1958.

[3]Community Research Associates (N.Y.): "Community Planning for the Problem of Indigent Disability." Journal of Public Health, 48:11, 1958.

the extent and the true characteristics of the problems. And, unlike the public health field, there have been no tests or diagnostic techniques to discover the problems in their incipient stages.

The Director of this study has been associated, for a number of years, with Bradley Buell of Community Research Associates (N.Y.) in the only efforts to acquire such epidemiological data. The first such effort, The Social Breakdown Index,[4] was begun in 1937. It was an attempt to maintain a continuing, community-wide register of families dealt with by official agencies and services. In 1948, Community Research Associates carried out the St. Paul (Minn.) Family Unit Report Study.[5] Here, for the month of November, was recorded all the families and individuals of Ramsey County who were receiving service or care from any public or private agency, local, State or Federal, for problems of social maladjustment, ill-health or dependency. Prevalence studies of the same type were made as subsequent demonstration research projects were launched in Winona County, Minnesota (1953, January),[1] San Mateo County, California (1954, January)[2] and Washington County, Maryland (1954, January).[3] These studies revealed

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[4]Community Chests and Councils (N.Y.): SOCIAL BREAKDOWN - A PLAN FOR MEASUREMENT AND CONTROL. Community Chests and Councils, Bulletin 101, 1939.

[5]Buell, B. and Associates: COMMUNITY PLANNING FOR HUMAN SERVICES. Columbia University Press, New York, 1952.

[1]Community Research Associates (N.Y.): Op. cit.

[2]Community Research Associates (N.Y.): Op. cit.

[3]Community Research Associates (N.Y.): Op. cit.

surprising similarity in the prevalence rates per thousand families in the community for the several problems referred to above.

The most significant revelation of these studies was that in all these communities there existed a small hard-core group, six percent of the families in the community, with two or all three of the problems of social maladjustment, ill-health and dependency. A further significant fact is that this small group were the recipients of as much as seventy-five percent of the services of the agencies. These families are referred to as multi-problem families.

The San Mateo County (Calif.) research project set up and operated a Disordered Behavior Roster.[6] The Roster contained all families dealt with by the official judicial and institutional services, local and State. Here one of the most significant facts was that the recidivist families, those presenting recurrent episodes of officially dealt with disordered behavior, were again a very small part of the total families on the Roster, but they represented a very disproportionate share of the work load of the official agencies, as much as fifty percent of the annual activity of the Juvenile Probation Department and Juvenile Court.

The casework operations of the San Mateo research project[1] confirmed what is a general clinical impression that these hard-core, disorganized and inadequate families often show evidence of school behavior problems

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[6]Coordinating Bureau for Family Services, San Mateo County, California. Part I - ORGANIZATION AND PROGRAM; Part II - PROGRESS REPORT - FAMILY CENTERED UNITS. January, 1960.

[1]Community Research Associates (N.Y.): Op. cit.

among their very young children and that truancy, drop-outs or delinquency are very common among their older children.

Research studies, particularly those of the Gluecks,[7] indicating that the potentiality for delinquency can be predicted by evaluating the quality of parental affection, supervision, discipline and family cohesiveness, and the Community Research Associates work on family diagnosis[1,2,3] bring the family into the foreground of this picture of childhood emotional deviation. However, heretofore, the families with the complexity of problems could be identified only by such devices as the Social Breakdown Index,[4] the Family Unit Report Study[5] or the Disordered Behavior Roster.[6] At this stage their troubles are many and their pathology well advanced.

Concerns about the classroom behavior of children have led the schools into efforts to determine how many children manifested deviant emotional behavior that affected classroom management and impeded educational progress. In numerous parts of the country studies brought about conclusions or estimates that the number of "emotionally disturbed" children varied from ten to twenty percent of the school population. These have varied all the way from teachers' guesses to careful psychological inquiry, but they have

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[7]Glueck, S. and Glueck, E.: PREDICTING DELINQUENCY AND CRIME. Harvard University Press, Cambridge, Mass., 1959.

[1]Community Research Associates (N.Y.): Op. cit.

[2]Community Research Associates (N.Y.): Op. cit.

[3]Community Research Associates (N.Y.): Op. cit.

[4]Community Chests and Councils (N.Y.): Op. cit.

[5]Buell, B. and Associates: Op. cit.

[6]Coordinating Bureau for Family Services: Op. cit.

created considerable interest in many quarters and a rash of plans to do something about the "emotionally disturbed". Most of the plans have pointed in the direction of traditional children's clinics and treatment centers. Little has been done to develop methods of helping the schools meet some of these problems through the educational system itself and through school personnel. In 1958 and 1959 the California State Department of Education conducted a pilot study of emotional disturbance among school children in four areas of the State.[8,9] In San Mateo County, one of the four areas, the finding was that from a sample of over 5,000 children, 9.8% were identified as emotionally handicapped. Subsequently, in participating school districts, some promising experimental programs were carried out, suggesting the kinds of intervention that the educational system might initiate in relation to this problem.

In view of these findings it seemed a reasonable hypothesis that many of the 9.8% emotionally handicapped children in the San Mateo County Schools might be the children of the six percent hard-core, multi-problem families and that identification of the children would mean identification of the families. If identification of these families could be accomplished while the children were in the early school grades it would mean that the community

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[8]California State Department of Education: THE EMOTIONALLY HANDICAPPED CHILD AND THE SCHOOL. A Preliminary Report to the California Legislature. California State Department of Education, Sacramento, California. December, 1959.

[9]California State Department of Education: THE EDUCATION OF EMOTIONALLY HANDICAPPED CHILDREN. A Report to the California Legislature. California State Department of Education, Sacramento, California. March, 1961.

services could know the families destined to be a considerable part of their work-load while those families were still young, had fewer children and were, presumably, still in early stages of disorganization or deterioration, offering a more favorable prognosis to treatment. It would thus be possible for the social adjustment services and the schools, in partnership, to develop much more effective programs of prevention and reduction of maladjustment problems.

Thus the search for a practical identification process begins.

The first step had been taken during the Community Research Associates demonstration research project in the prevention and control of disordered behavior in San Mateo County.[1] A behavior rating scale was developed as the result of a special study by Andrew Mikita.[10] This ten-item scale was felt to be an appropriate classroom screening technique for use in the present research study. It will be referred to as Behavior Rating Scale II (BRS II - Appendix p. 69).

A second step was the consideration of the Behavior Rating Scale used by the California State Department of Education as a screening technique in the identification of emotionally disturbed children.[8,11] The use of this scale seemed appropriate, was used, and will be referred to as Behavior Rating Scale I (BRS I - Appendix p. 67).

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[1]Community Research Associates (N.Y.): Op. cit.

[10]Mikita, A.: Unpublished Report, June, 1957.

[8]California State Department of Education: Op. cit.

[11]California State Department of Education: A PROCESS FOR EARLY IDENTIFICATION OF EMOTIONALLY DISTURBED CHILDREN. Bulletin of the California State Department of Education, Sacramento, California. 27:6, August, 1958.

Both rating scales were used in an effort to validate their usefulness as screening techniques.

In the light of these two developments and the resources of San Mateo County, the research project reported here was formulated. San Mateo County was the obvious and, indeed, the only place where this particular project could be conducted. It had continued to operate the Roster of disordered behavior families, thus providing a means of determining whether any child's family had multiple official behavior problems. The Coordinating Bureau for Family Services,[6] created by the county authorities, as a result of the Community Research Associates demonstration,[1] was operating special casework units in the Department of Health and Welfare, the Probation Department and the Office of the County Superintendent of Schools. In these units a selected group of recidivist, multi-problem families was under continuing casework treatment. This provided a known group of multi-problem families, with known diagnostic factors, as an experimental group. Furthermore, the Department of Health and Welfare had master indexes in its Mental Health and Social Service Divisions, permitting a check for dependency and mental health problems.

The San Mateo County Board of Education and the County Superintendent of Schools, James R. Tormey, willingly agreed to sponsor the project and to make one of their staff members available as its Associate Director. The project was further implemented by the fact that the Associate Director had been a member of the research team with the State Department of Education project, directing that program in San Mateo County.

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[6]Coordinating Bureau for Family Services: Op. cit.

[1]Community Research Associates (N.Y.): Op. cit.

The proposal was submitted to the Rosenberg Foundation of California with a request for funds to finance a two-year operation. The Foundation had financed the Community Research Associates three-year research demonstration and contributed for two years toward the cost of the Coordinating Bureau for Family Services. The grant of funds was made and the project was launched in March, 1960.

II. THE RESEARCH PLAN AND FINDINGS

The Hypothesis

The hypothesis formulated was that the observable behavior symptoms of young children in the school setting, measured by objective screening methods which indicate deviation from acceptable behavior, will also indicate the families with the greater potential for the production of disordered behavior.

The Objectives

The objectives were: (1) to test the validity of the two Behavior Rating Scales[8,10] on the same sample; (2) to develop a single behavior rating scale; and (3) to analyze the significant diagnostic differences between the experimental and control families.

Arrangements were made with the Coordinating Bureau for Family Services[6] to have its special service units in the Department of Health and Welfare (Social Service Division), the Probation Department and the Office of the County Superintendent of Schools refer families under treatment, with at least one school child, ten years of age or under, until an experimental group of one hundred children had been obtained.

The plan for screening by the use of the two behavior rating scales was discussed with the San Mateo County Board of Education and County Association of School Superintendents and their cooperation was assured. Principals and teachers were contacted and the purpose of the project and its method were explained to them. The resulting cooperation was most satisfying.

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[8]California State Department of Education: Op. cit.

[10]Mikita, A.: Op. cit.

[6]Coordinating Bureau for Family Services: Op. cit.

Both rating scales (BRS I and BRS II) were administered by the teacher of each classroom where one or more of the children of the experimental families was present. These children had been under the teacher's observation for at least three months and in the majority of classes for an entire school year.

The behavior rating scales were scored and the children from each classroom were ranked in order on each scale, and placed in three groups. Those ranking 1, 2 and 3 (high scoring) were referred to as Group A, those ranking 4 through 8 as Group B, and the rest (low scoring) as Group C. The distribution of scores appeared to warrant considering the top eight, about twenty-five percent of the class as "high scoring". High scoring children were those with the most disturbed or disturbing behavior.

Using BRS II, a matching control child from each classroom was selected at random from Group C, provided that the family was not known to the Roster of Disordered Behavior. This provided a control group of families to be compared with the experimental families. The details of this process are reported in Section III.

Statistical analysis of data from the behavior rating scales resulted in two findings:

(1) that both rating scales identified almost exactly the same children in the several groups.

(2) that eleven of the most discriminating items from both scales constituted a reliable and adequate instrument for identification of behavior problem children.

Seventy-two percent of the one hundred experimental group children were identified by one or the other Rating Scale as being in Group A or B. More significantly, 80% of the sixty-seven experimental <u>families</u> were re-identified by having their children fall in Group A or B.

As a further check on the Behavior Rating Scales and the degree to which they might identify young children whose behavior reflects families with problems, the families of all children from Group A and a random sample from Group B, were processed through

1. The Roster of Disordered Behavior Families.
2. The Mental Health Division (Department of Health and Welfare) master file, to determine if they had had psychiatric service.
3. The Social Service Division (Department of Health and Welfare) master file, to determine whether any family was receiving financial assistance.

The findings that follow do not include those children from the experimental group who were in Group A or B. Their families were known Roster families. All other children who ranked 1, 2, or 3 (Group A), or 4-8 (Group B) on either BRS I or BRS II were included.

GROUP A (Rank 1, 2, 3)

Total number = 360 children

Unknown to any agency..... 181 families or 50%

Known to one or more agencies..... 179 families or 50%

Known to	Number of families
Roster, Mental Health and Welfare.....	26
Roster and Mental Health.....	6
Roster and Welfare.....	32
Mental Health and Welfare.....	7
Roster only.....	27
Mental Health only.....	27
Welfare only.....	54
Total.....	179

GROUP B (Rank 4-8) Random Sample

Total number processed = 97 children

Unknown to any agency..... 61 families or 62%

Known to one or more agencies..... 36 families or 38%

Known to	Number of families
Roster, Mental Health and Welfare.....	4
Roster and Mental Health.....	0
Roster and Welfare.....	8
Mental Health and Welfare.....	0
Roster only.....	9
Mental Health only.....	3
Welfare only.....	12
Total.....	36

In the light of all the evidence it appears to be a reasonable conclusion that we have developed a behavior rating scale with which a classroom teacher can identify a significant proportion of young children whose school behavior indicates families with problems resulting in official behavior disorder or financial dependency, or both.

The diagnostic study of the control families was made by a highly qualified caseworker. A letter was sent to each of these families, explaining the purpose of the project, introducing the worker and requesting their cooperation. The intent was to consult them about the factors in their family living and parental functioning that accounted for the fact that their children had "good" behavior ratings. Since such was the case the entree was favorable. Even so, it was a revelation to find how ready they were to reveal information about themselves and to discuss their concerns, their aspirations, their problems and what they were doing about them.

The caseworker interviewed the parents in the home. In most instances this also provided the opportunity to observe the children. The data obtained was recorded on the Family Classification and Case Management Schedule (Appendix p. 83) used by the special family service units of the Coordinating Bureau for Family Services.[6] Assessment was made of the degree of intensity of such problems as they existed. The diagnostic factors were compared with the family pathology classifications used by the Coordinating Bureau. Since none of the families fell clearly within those categories, additional classifications were formulated.

Inasmuch as the cases (experimental families) referred from the Coordinating Bureau had been recorded on this same schedule, it was

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[6]Coordinating Bureau for Family Services: Op. cit.

possible, by statistical analysis and scrutiny, to make comparison between the two groups in terms of the diagnostic factors. This analysis is detailed in Section IV.

Here, again, we see clear differences between these two groups of families. In the experimental group families we find the pervasiveness and intensity of problems and the pathology which results in community concern and attention. We find the seeds of future trouble, promising it into the next generation. In the control group we find the families managing their own affairs, coping with their problems. For the most part there is the promise of reasonably satisfying family life and adequate social adjustment. We find that for a fourth of them the complexity of society's requirements, the presence of juvenile delinquency in their neighborhoods, the pressures for educational achievement create burdensome anxiety that frays at the family fabric, but they manage to cope with it. For a small group the scrutiny of a skilled caseworker perceives personality problems that permeate some aspect of family functioning, making the family life less wholesome, providing a less satisfactory setting for healthy emotional development of children. Even here, however, the families are coping, at least to the degree that they have not laid their problems in the community's lap.

Viewing the total picture, it is reasonable to conclude that a screening process such as the behavior rating scale here developed will identify a significant proportion of the children and the families for whom a program of preventive intervention should be initiated. Such a program should be equipped with all the resources that the joint effort of school and community can command. Such an effort is outlined in Sections V and VI.

III. DEVELOPMENT OF THE A>M<L BEHAVIOR RATING SCALE

METHOD

Sample. The samples under study were drawn from a population of public school children in 12 elementary school districts (38 schools, 120 classrooms), kindergarten through fifth grade.

Experimental Group:

Families meeting the established criteria were referred to the research project from the Coordinating Bureau for Family Services.[6] The criteria for referral of families to the project were as follows:

1) Roster recidivist family.
2) Two years residence in San Mateo County.
3) One or more children living in the home, under 10 years of age on July 1, 1960, and attending public school.

Using the above criteria, 67 families were referred to the project. One hundred children, under 10 years of age on July 1, 1960, who were from these families, provided the basis for selecting the school districts and classrooms included in the study. These 100 children comprise the experimental group.

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[6]Coordinating Bureau for Family Services: Op. cit.

Control Group:

A control group of 100 children was selected from the same school population according to the following criteria:

1) Same classroom as experimental child.
2) Each child in the control group was randomly selected from among those children who presented no particular behavior problem in the classroom as evidenced by the rating received on Behavior Rating Scale II (from the lower 75% of each class or low scoring group).
3) Same sex as experimental child.
4) Under 10 years of age on July 1, 1960.
5) Same racial background as experimental child.
6) Two years residence in San Mateo County.
7) Family not known to the Roster of Disordered Behavior Families.

Residual Group:

All other children not identified as experimental or control subjects.

Behavior Rating Scales. All children in each identified classroom were rated by the classroom teacher on Behavior Rating Scales I and II (Appendix pp. 67, 69). Experimental children were not identified to the teachers. The classroom was the frame of reference and each child was rated in terms of his behavior in relation to that of his classmates, as perceived by his classroom teacher. Most ratings were done in April and May of 1960, with additional classes being rated in November, 1960. There was no attempt made to define

or to standardize the interpretation of terms used in the rating scales.

Behavior Rating Scale I: (BRS I)

Behavior Rating Scale I is essentially the Teacher Rating Scale that was developed (by the California State Department of Education)[8] and used as one instrument in a research study of emotionally handicapped children. It was designed for use by the classroom teacher to assist in the identification of children with behavior problems.

The items on Behavior Rating Scale I are identical with those on the State Teacher Rating Scale but the rating categories were changed as follows:

	Rating				
STATE TEACHER RATING SCALE	Seldom or never (1)	Not very often (2)	Not observed (3)	Often (4)	Most of the time (5)

	Rating				
BEHAVIOR RATING SCALE I	Seldom or never (1)	Not very often (2)	Often (3)	Most of the time (4)	All of the time (5)

"Not observed" was considered an unnecessary category which interrupted the rating sequence and for this reason was not

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[8] California State Department of Education: Op. cit.

included. Behavior Rating Scale I was administered by classroom teachers to the total selected school population but was not used in the selection of the control group.

Behavior Rating Scale II: (BRS II)

Behavior Rating Scale II was developed by Andrew Mikita,[10] Staff Psychologist with the Family Research Center of the Community Research Associates, San Mateo County Project on Disordered Behavior.[1] It was derived from 50 items based on the ten significant traits appearing in the Glueck Delinquency Prediction Instruments.[7] The scale as used by Mikita was administered by the classroom teacher to male subjects who were rated on a 3-point rating scale. The 10 suggested significant items from this Community Research Associates Scale comprise Behavior Rating Scale II of the present study. A 5-point scale was substituted for the 3-point scale. The categories were the same as those used in Behavior Rating Scale I (from "Seldom or never" to "All of the time").

Behavior Rating Scale II was administered by classroom teachers to the total selected school population and was used as the basis for selection of the control group.

Procedure. Following the administration of the rating scales by the classroom teacher, the scales were scored. Each item received the value

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[10]Mikita, A.: Op. cit.

[1]Community Research Associates: Op. cit.

[7]Glueck, S. and Glueck, E.: Op. cit.

of the rating as checked by the teacher. The total possible score for BRS I was 40 points (8 items, possible rating per item: 1 to 5 points). The total possible score for BRS II was 50 points (10 items, possible rating per item: 1 to 5 points). Children receiving the highest scores presented the most disturbing or disturbed behavior in the classroom. Children were ranked in terms of their scores (from high to low) on BRS II. All children whose rank was 1, 2, or 3 (high scoring) will be referred to as Group A. All children whose rank was 4, 5, 6, 7, or 8 will be referred to as Group B. All other children in each classroom will be referred to as Group C (low scoring).

The same procedure was followed with BRS I. All data relative to BRS I and BRS II was coded, punched, validated and processed through IBM.

At the time of the data processing there were 95 control children who had met the established criteria and whose families had participated in the Case Management Schedule[6] interview. There were 115 experimental children, 95 of whom were paired with a control child. The remaining 20 experimental children provided a pool from which 5 subjects were selected as 5 additional control subjects were confirmed. The coded data on 2,872 children included: case number (identifying experimental, control or residual subjects), school district, school, grade, sex, teacher, birth date (month and year), family number (for experimental families), race, rating for

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[6]Coordinating Bureau for Family Services: Op. cit.

each item on BRS I and BRS II, total scores, and Group Identification (A, B, or C) on BRS I and BRS II.

Tables 1, 2, 3, 4, and 5 show the distribution of subjects in terms of several variables: sex, age, grade level, and grouping in terms of total score on BRS I and BRS II.

TABLE 1

THE NUMBER OF MALE AND FEMALE SUBJECTS
IN THE EXPERIMENTAL, CONTROL, RESIDUAL AND TOTAL GROUPS.

Group	Male	Female	Total
Experimental	60	55	115
Control	52	43	95
Residual	1406	1256	2662
Total	1518	1354	2872

There were 164 more boys than girls in the total sample of 2,872. There were 9 more boys than girls in the control group. (Table 1)

TABLE 2

THE YEAR OF BIRTH AND AGE* FOR SUBJECTS IN THE EXPERIMENTAL, CONTROL, RESIDUAL AND TOTAL GROUPS.

Group	1955+ 5 yrs & under	1954 6 yrs	1953 7 yrs	1952 8 yrs	1951 9 yrs	1950-47 10 yrs & over	Total
Experimental	2	23	20	33	18	19	115
Control	3	21	20	18	19	14	95
Residual	78	503	523	649	457	452	2662
Total	83	547	563	700	494	485	2872

*Age as of July 1, 1960.

The total population was distributed fairly evenly in terms of age with 8 year olds representing the largest single age group, 24%.

TABLE 3

THE GRADE LEVEL OF SUBJECTS IN THE EXPERIMENTAL, CONTROL, RESIDUAL AND TOTAL GROUPS.

Group	Kdg.	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Total
Experimental	16	30	20	27	15	7	115
Control	14	22	17	21	14	7	95
Residual	343	586	503	707	335	188	2662
Total	373	638	540	755	364	202	2872

Table 3 shows the Grade distribution of the total population, including the experimental and control groups.

TABLE 4

THE DISTRIBUTION OF TOTAL SCORES ACCORDING TO GROUPS A, B, AND C ON BEHAVIOR RATING SCALE II FOR SUBJECTS IN THE EXPERIMENTAL, CONTROL, RESIDUAL AND TOTAL GROUPS.

Group	Group A Rank 1-3	Group B Rank 4-8	Group C Rank 9 +	Total
Experimental	31	33	51	115
Control	0	10*	85	95
Residual	279	471	1912	2662
Total	310	514	2048	2872

*Even though these 10 cases fell in the lower 75% of the class in Total Score on Behavior Rating Scale II, they ranked 7 or 8 and so were coded as Group B. In such cases there were no other eligible controls from Group C.

55% of the experimental group fell into Group A or B on Behavior Scale II. 28% of the Residual Group fell into these categories on BRS II. Groups A and B include children with high ratings or more undesirable classroom behavior as observed by the classroom teacher. (Table 4)

TABLE 5

THE DISTRIBUTION OF TOTAL SCORES ACCORDING TO GROUPS A, B, AND C ON BEHAVIOR RATING SCALE I FOR SUBJECTS IN THE EXPERIMENTAL, CONTROL, RESIDUAL AND TOTAL GROUPS.

Group	Group A Rank 1-3	Group B Rank 4-8	Group C Rank 9 +	Total
Experimental	41	30	44	115
Control	2	10	83	95
Residual	299	443	1920	2662
Total	342	483	2047	2872

61% of the experimental group fell into Group A or B on Behavior Rating Scale I. 28% of the residual group fell into these categories on BRS I. (Table 5)

If we consider only the 100 experimental children from 67 Roster families for whom we have 100 control children from 100 families, then we have the following percentages:

72% of these experimental children were identified on BRS I or BRS II, Group A or B.

65% on BRS I : 58% on BRS II Group A and B.

54 of the 67 experimental families or 80% were identified on BRS I or BRS II.

44% on BRS I : 31% on BRS II Group A

37% on BRS I : 38% on BRS II Group B

76% on BRS I : 64% on BRS II Group A and B.

R E S U L T S

When each of the variables* under consideration was held constant for the total population studied (N=2,872), significant correlations were to be found as follows; (Table 6, Appendix p. 71)

Item 1 (BRS I): "This pupil gets into fights or quarrels with other pupils" has a correlation of .50 or higher with Items 5 and 6 of BRS I and Items 14, 15, 16, 17, 18, 19, 21 and 22 of BRS II. The highest correlation is found with Item 18 - "Starts fights easily". (.84)

Item 2 (BRS I): "This pupil has to be coaxed or forced to work or play with other pupils" has a correlation of .50 or higher with Item 7 of BRS I and Item 22 of BRS II. The highest correlation is found with Item 7 - "Is unhappy or depressed". (.55)

Item 3 (BRS I): "This pupil has difficulty learning" has a correlation of .45 with Item 5 (BRS I) and Item 16 (BRS II).

Item 5 (BRS I): "This pupil makes unusual or inappropriate responses during normal school activities" has a correlation of .55 or higher with Items 1 and 6 of BRS I and Items 15, 16, 17, 18, 19 and 21 of BRS II. The highest correlation is found with Item 17 (BRS II) - "Enjoys disrupting class discipline". (.65)

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*Age, sex, grade, BRS I, BRS II, Experimental, Control.

Item 6 (BRS I): "This pupil behaves in ways which are dangerous to self or others" has a correlation of .55 or higher with Items 1 and 5 on BRS I and Items 14, 15, 16, 17, 18, 19 and 21 on BRS II. The highest correlations are found with Item 1 (BRS I) - "Gets into fights or quarrels with other pupils" and Item 18 (BRS II) - "Starts fights easily". (.71)

Item 7 (BRS I): "This pupil is unhappy or depressed" has a correlation of .50 or higher with Items 2 and 8 on BRS I and Items 20 and 22 on BRS II. The highest correlation is found with Item 8 (BRS I) - "Becomes sick when faced with a difficult school problem or situation". (.56)

Item 8 (BRS I): See Item 7 (BRS I) above. This is the only correlation higher than .47 (Item 22, BRS II).

Item 14 (BRS II): "Is very assertive in his behavior toward other children" has a correlation of .62 or higher with Item 1 of BRS I and Items 15, 16, 17, 18, 19 and 21 of BRS II. The highest correlation is found with Item 1 (BRS I) - "Gets into fights or quarrels with other pupils". (.73)

Item 15 (BRS II): "Cannot control his desires" has a correlation of .50 or higher with Items 1, 5 and 6 on BRS I and Items 14, 16, 17, 18, 19, 21 and 22 on BRS II. The highest correlation is found with Item 21 (BRS II) - "Is very impulsive". (.73)

Item 16 (BRS II): "Is very restless" has a correlation of .50 or higher with Items 1, 5 and 6 on BRS I and Items 14, 15, 17, 18, 19, 21 and 22 on BRS II. The highest correlation is found with Item 21 (BRS II) - "Is very impulsive". (.74)

Item 17 (BRS II): "Enjoys disrupting class discipline" has a correlation of .50 or higher with Items 1, 5 and 6 of BRS I and Items 14, 15, 16, 18, 19, 21 and 22 of BRS II. The highest correlation is found with Items 18 - "Starts fights easily" and 21 - "Is very impulsive". (BRS II) (.74)

Item 18 (BRS II): "Starts fights easily" has a correlation of .51 or higher with Items 1, 5 and 6 of BRS I and Items 14, 15, 16, 17, 19, 21 and 22 of BRS II. See Item 1 (BRS I).

Item 19 (BRS II): "Is very obstinate" has a correlation of .55 or higher with Items 1, 5 and 6 of BRS I and Items 14, 15, 16, 17, 18, 21 and 22 of BRS II. The highest correlation is found with Item 17 (BRS II) - "Enjoys disrupting class discipline". (.73)

Item 20 (BRS II): "Is overly sensitive to criticism" has a correlation of .50 or higher with Item 7 of BRS I and Item 22 of BRS II. The highest correlation is found with Item 22 (BRS II) - "Can be very moody". (.62)

Item 21 (BRS II): "Is very impulsive" has a correlation of .50 or higher with Items 1, 5 and 6 of BRS I and Items 14, 15, 16, 17, 18, 19 and 22 of BRS II. The highest correlation is found with Items 16 - "Is very restless" and 17 - "Enjoys disrupting class discipline". (BRS II) (.74)

Item 22 (BRS II): "Can be very moody" has a correlation of .50 or higher with Items 1, 2 and 7 of BRS I and Items 15, 16, 17, 18, 19, 20 and 21 of BRS II. The highest correlation is found with Item 7 (BRS I) - "Is unhappy or depressed". (.66)

There were no significant correlations for Item 4 (BRS I) and Item 23 (BRS II).

When the Kuder-Richardson 21 reliability formula* was applied R=.7396 when Behavior Rating Scale I was held constant, and R=.9103 when Behavior Rating Scale II was held constant. These results are for the total population studied (experimental, control and residual groups: N=2,872).

Interpretation: The behavior rating scales serve the purpose of helping the teacher record, in an orderly fashion, various kinds of symptomatic behavior.

In an attempt to understand better the internal structure of Behavior Rating Scales I and II, a factor analysis of the items of both scales was undertaken simultaneously. Thus, the factor analysis was based on 24 variables (12 items from BRS I and the over-all score for BRS I plus 10 items from BRS II and the over-all score for BRS II). Intercorrelations were determined by standard product-moments formulas, and the intercorrelation matrix was factored by the method of principal

* $R = \left[\left(\frac{k}{k-1}\right)\left(1 - \frac{\sum \xi x_i^2}{\xi x_t^2}\right)\right]$ Kuder, G. F. and Richardson, M. W.: "The Theory of the Estimation of Test Reliability." Psychometrika, Vol. 2, pp. 151-160, 1937.

components. Those four principal components associated with latent roots greater than one were then rotated according to the varimax criterion.

Such analyses were carried out on the experimental and control groups separately, males and females separately, and on the total sample. Since the results were substantially the same in these different analyses, we shall restrict our interpretations to the factor analysis of the total sample of 2,872 youngsters.

As shown in Table 7 (Appendix p. 73) three substantial factors emerged. Of these, the strongest appears clearly to be an "Aggressive-Outgoing" factor (A>) as its largest loadings occur for variable 1, 5, 6, 10, 13-19, 21 and 24. A second factor - with strong loadings on variables 2, 7, 8, 20 and 22 - may appropriately be described as a "Moody-Internalizing" factor (M<). Factor 3 (L) seems to reflect "Learning" as it is highly loaded on variables 3, 9 and 12. The fourth rotated factor seems too unsubstantial to interpret.

In examining the data, there are two items - No. 4 (BRS I) and No. 23 (BRS II) that seem to contribute very little to the total scale. Apparently they are sufficiently ambiguous to be taken as positive or negative behavior by teachers. These two items have been discarded.

There are 5 items on the two scales that make a very substantial contribution and seem to contain a "general" characteristic common to many other items. They are as follows:

No. 1 (BRS I), Nos. 16, 17, 19 and 21 (BRS II). These items are also those identified by factor A>.

Other items with a substantial contribution but with less of a "general" characteristic are Nos. 2, 7 and 8 (BRS I) and Nos. 20 and 22 (BRS II). These items are also those identified by factor M<.

Item 3 (BRS I) is somewhat unique and has been identified as factor (L).

The suggested A>M<L Scale includes 5 Factor A> items, 5 Factor M< items, and 1 Factor L item. These have been arranged in alternate fashion with Factor L being item 11. The Scale on page 31 shows in more detail the rational for possible exclusion of items 6, 14, 18, 5 and 15.

It is possible with the identification of these 3 major factors to derive 3 major factor scores for any individual child.

A>M<L BEHAVIOR RATING SCALE

(Revised BRS I and BRS II)

FACTOR	This Pupil
I (A)	1. GETS INTO FIGHTS OR QUARRELS WITH OTHER PUPILS (1)*
	(6) Behaves in ways which are dangerous to self or others.
	(14) Is very assertive in his behavior toward other children.
	(18) Starts fights easily.
II (M)	2. HAS TO BE COAXED OR FORCED TO WORK OR PLAY WITH OTHER PUPILS. (2)
I (A)	3. IS VERY RESTLESS. (16)
II (M)	4. IS UNHAPPY OR DEPRESSED. (7)
I (A)	5. ENJOYS DISRUPTING CLASS DISCIPLINE. (17)
	(5) Makes unusual or inappropriate responses during normal school activities.
II (M)	6. BECOMES SICK WHEN FACED WITH A DIFFICULT SCHOOL PROBLEM OR SITUATION. (8)
I (A)	7. IS VERY OBSTINATE. (19)
II (M)	8. IS OVERLY SENSITIVE TO CRITICISM. (20)
I (A)	9. IS VERY IMPULSIVE. (21)
	(15) Cannot control his desires.
II (M)	10. CAN BE VERY MOODY. (22)
III (L)	11. HAS DIFFICULTY LEARNING. (3)

*Number in parenthesis refers to original number of item on BRS I and BRS II.

These 11 items are suggested as a single behavior rating scale and will be referred to as A>M<L Behavior Rating Scale. The revised scale is as follows:

1. Gets into fights or quarrels with other pupils.
2. Has to be coaxed or forced to work or play with other pupils.
3. Is very restless.
4. Is unhappy or depressed.
5. Enjoys disrupting class discipline.
6. Becomes sick when faced with a difficult school problem or situation.
7. Is very obstinate.
8. Is overly sensitive to criticism.
9. Is very impulsive.
10. Can be very moody.
11. Has difficulty learning.

This leaves 5 items unaccounted for: Nos. 5 and 6 (BRS I) and Nos. 14, 15 and 18 (BRS II). The extent to which any one of these items might increase or decrease the reliability of the revised 11-item scale (A>M<L-BRS) is a logical next step for investigation.

IV. ANALYSIS OF DIAGNOSTIC FACTORS

As indicated earlier, the experimental group was composed of behavior problem families under active treatment by the special units of the Coordinating Bureau for Family Services in the Department of Health and Welfare (38 families), Probation Department (17) and Office of the County Superintendent of Schools (12). The information was furnished on the Family Classification and Case Management Schedule required by the Coordinating Bureau. One schedule was omitted from this analysis because of incomplete data.

General Characteristics

Because of the method of selecting the control group ("C"), they came from the same neighborhoods. These were almost entirely lower middle class or lower class families, many of them living in the so-called "tract" areas. Because so many experimental ("X") families were receiving Aid to Needy Children this tended to concentrate these families in the low rent sections. Since the children were matched on race, the proportion in both groups was the same, one-fifth being Negro families. Religion showed some contrast, the "X" group having 68% Protestant, 29% Catholic, one family of mixed religion, one Mormon family, and no information on ten. The "C" group had 52% Protestant, 30% Catholic, 13% mixed religion, two Mormon, one Jewish family, and no information on two.

The "X" group families tended to be about five years older than the "C" group, 58% of these parents being under 40 years of age against 75% for the "C" group. The greatest concentration for the "X" group was in the 35-40 age range, for the "C" group 30-35 range.

As might be expected, the size of the "X" families was larger, three-fourths of them having 5 or more children, against one-fourth for the "C" group. The concentrations for the "X" group were in the 4, 5 and 6 child families, for the "C" group in the 2, 3 and 4 child families. The average number of children per family was: "X" group 5; "C" group 3.76.

The sibling position of the children differed noticeably. Sixty-five percent of the "C" children were the first or second child, while in the "X" group, 55% were the third, fourth or fifth child. (Table 8, Appendix p. 75). The "X" families had the larger number of children in the older age brackets.

Families in the "X" group were the recipients of a great deal of official agency attention. (Table 9, Appendix p. 77). Seventy percent of children from families receiving help from more than one Agency Service are in Groups A and B; 66% of children from families receiving Financial Assistance only, or School Social Service only are from Groups A and B. Forty percent of children from families under the Probation Department are in Groups A and B; 33% of children from families receiving Social Service only are in Group B, none in A. In contrast the "C" group included two families, one unmarried mother and one deserted wife, receiving public assistance.

The marital status of the "X" families at the time of the study was: married couples 30, divorced 16, separated 11, unmarried mother 3, common-law union 2, widow 1, no information 3. This only hints at the extent of pathology in these families whose histories display a tragic record of desertion, separation, divorce, plural marriages, alcoholism, child neglect, truancy, delinquency and school

drop-outs. Interestingly, there is little evidence of serious crime or commitment for mental illness. This is in accord with the date from the Community Research Associates Disordered Behavior research project,[1] which indicated that these two types of official disorder fall in two different groups of families.

By contrast, the "C" group families were all married couples except for one deserted wife, one widow and one unmarried mother. The family classification assigned to these families is as follows:

	Family Type	Number of Families "X" Group	"C" Group
I.	Normal.	0	59
IA.	Anxiety Burdened	0	25
IB.	Character Defect.	0	16
II.	Neurotic Anxious, Perfectionist . .	10	0
III.	Socially Ineffective, Parentally Inadequate	34	0
IV.	Socially Adequate, Emotionally Destructive Parents .	17	0
V.	Non-Conforming, Hostile	5	0
	Unclassified.	1	0
	Total	67	100

The distribution of children according to these family types is shown in Table 10 (Appendix p. 79).

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[1] Community Research Associates: Op. cit.

Description of Family Classifications

There is an essential difference between the classifications into which the "X" families and the "C" families fall. Types II, III, IV and V are classifications of pathology. From society's point of view the pathology is clear and must be dealt with. There is an aura of family disorganization, of deterioration. The families do not recognize their problems or refuse to admit that they exist. They tend not to seek help with their problems, except for financial need, and many are resistant or hostile to efforts to deal with them. One is very conscious that many of the adults have had early childhood deprivations, faulty parenting, early, unwise or plural marriages. Low self esteem, distorted value systems, lack of integration into community life and activities are characteristic. They tend to present problems not just in one area but in all the areas of adult functioning, marital and financial functioning, child rearing and child functioning. The difference between these classifications is mainly one of degree as to their relative failure to cope with their problems.

On the contrary, the normal families and the IA and IB groups do cope with life and such problems as they have. They are organized families, stable, cohesive, goal-directed. They have incorporated into themselves the value system of the community. Those who have problems tend to have them only in one area of life functioning. They are aware of them, tend to seek help for them, or are accepting when it is offered.

There follows a brief description of each of the classifications. The first four, Types II, III, IV and V, were derived from the family diagnosis research of Community Research Associates, as used in the

San Mateo Disordered Behavior Project and prescribed by the Coordinating Bureau for Family Services for use by its casework units. The other three, Types I, IA and IB, were derived from the diagnostic studies of the one hundred control families and formulated by the project staff. These studies were made in accordance with the Family Classification Schedule so that the diagnostic factors are comparable.

The descriptions are in terms of the five major areas of life functioning under which the diagnostic factors are grouped: Adult Functioning, Marital Functioning, Financial Functioning, Child Rearing (Parental) Function, Child Functioning. Each functional area received an assessment as to the degree of severity of the problems in that area: (1) No significant problems, (2) Moderate problems, (3) Severe problems. Likewise, a total assessment was made for the family as a whole. Types II, III, IV and V are in an ascending scale of severity of pathology, particularly from the point of view of impact on the community. Type II had two-fifths with severe problems, III had slightly more than two-fifths, IV had one-half and V had all families assessed as having severe problems.

Type II - Neurotic Anxious, Perfectionist

This family is marked by its neurotically anxious reactions to situational stress, difficulty in inter-relationships and social achievement. Its goals are identified with the cultural values and standards of the community. The pathology lies in over-emphasis placed on perfectionism in the achievement of these goals.

The adults seem overwhelmed by anxiety. There is emotional withholding and lack of self expression. They are likely to be

threatened by authority, sometimes disrespect it. One partner or the other is likely to become aware that there is something within himself or about his partner that causes anxiety in the relationship. The result is jealousy, anger, nagging and depreciation of the partner. Sometimes there is exploitation of the partner. As a result the marital situation is fragile and divorce is common. Three-fifths of these families were divorced or separated and all but one were receiving Aid to Needy Children.

Their distorted relationships often result in difficulties in the area of employment. Discord about handling money and home management often result.

These parents transmit their anxiety and frustrations to their children. They are fearful of failures, especially school failures. Over-punitiveness and over-permissiveness are both present. Sometimes a child is resented. Critical, angry attitudes are shown.

The exposure to all this of the children stunts their emotional growth. They reflect the family pattern of inhibition and anxiety. Feelings are internalized, resulting in school failures. There is negation of parental authority rather than aggressive acting-out.

Type III - Socially Ineffective, Parentally Inadequate

These families are not greatly burdened with anxiety. Their social motives do not run counter to cultural ideas for family behavior, but they do not succeed in functioning adequately in any of the areas. They are unable to compete as job seekers. They do not manage to give proper care to their children. They mean to conform to society's requirements but lack the basic capacity to do so.

Adults are immature, dependent, sometimes infantile. Ego strength and self esteem are low. Self gratification runs strongly. They rely on others for support and problem-solving. They are a headache to the social agencies. Three-fourths of the "X" group were on public assistance, all but one of the rest were school disciplinary cases.

This is a group of families permeated with desertion, non-support, neglect, illegitimacy, alcoholism or heavy drinking, mental illness or retardation. The family unit, including parents, is often characterized as a "bunch of children living together".

In the marital relationship the partners are preoccupied with their own needs, unable to respond to each others needs. They are immature, irresponsible marital partners with unrealistic demands and expectations of each other.

Their ineffectiveness is reflected in poor work records, low earnings, poor management and debts.

As parents they are too occupied with their own needs to understand their children's needs and to do much about them. Physical neglect is common, as is casualness about school attendance and children's behavior. They have some affection for and concern about their children, but fail in effective parenting through inconsistency.

All this seriously affects the children's emotional health. There is great danger that the children will reproduce the parental pattern in adulthood. They find the parents poor objects for identification. Children are shy, insecure, immature. They tend to be poor in school attendance, under-achievers and drop-outs. School personnel become concerned about the evident child neglect. Acting-out behavior may take the form of truancy or runaway.

Type IV - Socially Adequate, Emotionally Destructive Parents

These families, in many respects, represent a social contradiction. They are socially conforming. Parents may be highly successful in income production, income and household management. They function well in the community. Material possessions, a "nice" home are emphasized.

The pathology in this social functioning lies in the fact that these accomplishments result from an excess of self-interest, an overstress of some form of status, conformity or personal prestige. This pattern dominates the marital and familial relationships. The marital partners tend to over-control each other. Each is critical of the other. They are highly competitive, skillful in manipulating situations. Though the relationship is basically lacking in sympathy and understanding, fraught with hostilities and frictions, divorce or separation is rare. In this "X" group nine-tenths of the families were still married couples.

These parents often tend to be concerned with their own strivings, ignoring the children as individuals and demanding inappropriate levels of responsibility or performance. There is little affectional response, little warmth communicated to the children. Often children are emotionally exploited by one parent as against the other. Bribing, coercing, scapegoating are manifestations. Parents are likely to be hostile to children when achievement is low.

Discipline is likely to be rigid. Cooperation between parents with regard to it is often missing. Children are more likely to be exploited to suit the needs of the parents.

The destructive parenting results in aggressive acting-out behavior that is often incompatible with the family's observable standards.

Rebellion, school trouble, delinquency are common, and the parents have a great tendency to blame outside forces; the school, the community, the police. All the families in this "X" group, save one, were cases with the Juvenile Probation Department or the schools.

Type V - Non-Conforming, Hostile

This group of families is characterized by aggressive disregard for society's laws and patterns of conduct, and by their deliberate exploitation of people, agencies and the community.

The adults lack two essential qualities for family functioning, a capacity for meaningful personal relationships and a normally social functioning conscience. Marital functioning is marked by cruel and exploitive behavior, hostility, physical abuse. Emotionally deprived, they are in conflict with each other just as they are with society.

Occupational capacity is interfered with by aggressive antagonism to employers and fellow employees. Family economic practices are apt to be chaotic. Incurring debt and "chiseling" are ways of expressing their hostility. Like Type III, they are "dead beats", not out of dependency but as an expression of their unsocial character.

Like Type IV, these parents are emotionally destructive to their children, but in this case deliberately and consciously so. They are abusive, exploitive, giving little or no affection. Children are encouraged to defy authority, to be actively aggressive toward others, and even to engage in criminal activities.

The disordered behavior patterns of both adults and children are likely to be repetitive, characterized by clear cut aggressive attacks upon persons and property. They do not learn by experience, nor do

they respond to social treatment. They are in defiance of the community and the school and they encourage their children to be likewise. They represent the extreme of family pathology.

The Control Group Classifications

The study of the control group of families represents the first effort known to the writer to describe the so-called "normal" family in terms of the diagnostic factors related to family and individual functioning. In one sense all the control families were normal in that they did not present trouble to the community, not being recorded on the Disordered Behavior Roster. It may well be that they were regarded as normal by their neighbors. They are cohesive, organized, intact families. The parents are "in charge" and are coping with life's problems. Only one family had a mentally ill parent, one contained a divorced parent, one an unmarried mother, one a deserting father and one a serious problem of alcoholism.

The general impression, to quote a report by the caseworker who made the diagnostic study, is a picture of "the homes of the American Common Man and the American dream in evolution, based on strong hope for a better future and, therefore, capacity for postponement of gratification and sacrifice. Industry, skills and hard work are the tools on the job or (for the children) in school. Love and mutual support, sharing of responsibility and faithfulness to personal commitments characterize the parents. Ability to subordinate personal needs to the nurturing of the young gives evidence of maturation. Acceptance of parental education by the young varies in accordance with the degree to which parents are able to be restrictive out of

objective considerations rather than personal emotional needs. These are the traits of every 'normal' human being, seen clear and uncomplicated through the windows of 'tract house' dwellers."

This is the general characterization. However, these families, like every one in the community, have some troubles and problems. Some are from external stress, some are problems of intra-familial relationships or social relationships. Careful diagnostic scrutiny of the several areas of family functioning brought these out in sharp focus. It indicated a division of the control families into three types, two of them having slight deviations from the quite normal, almost ideal families of the first type. It is not because there is serious pathology. The distinction is made in the interests of teachers, guidance personnel and social workers, because certain symptomatic evidence may spot these as families that would benefit by understanding and supportive help. For example, the children of ten of these families ranked 7 or 8 in Behavior Rating Scale II. Some are the slow-learner, under-achiever, fearful-of-school types.

Type I - Normal Family

These are cohesive, well-organized, intact families. The parents were in charge and they coped with life's burdens and problems.

These families began their child rearing and continued it with a minimum of disagreement and conflict because they brought to the marriage, from their own backgrounds, already built-in standards, expectations and conformity to social behavior. They are parents capable of organizing family living by means of strong wishes, purposiveness, regulating routines in the interests of aims and goals for which they

are willing to postpone immediate gratification. They have integrated into their family life the value system of their community.

The marriage has complementarity. The respective life styles of the marital pair are sufficiently alike as not to require much clarification. There is love, mutual support, shared responsibility. Importantly, there is freedom to communicate, to achieve a comfortable modus operandi for handling the normal disagreements of marriage and child rearing.

The parents provide good objects for identification. Their goals are collective family happiness, economic security and improvement of socio-economic status, education of offspring. There is recognition of the needs of children for stimuli to growth, for self assertion, respect for them as individuals. Affection is warmly expressed. Discipline is consistent. It has the restrictive quality characteristic of lower-middle class families directed at developing good habits, and the wish to conform to society and not get into trouble.

Children are well-adjusted and responsive. They have self identity. They make easy adjustment to school, community contacts and home responsibilities. They have natural affection for, and rivalry with siblings.

Type IA - Anxiety Burdened

These families are cohesive, organized, intact families. Except for a few instances, they have no significant problems of adult functioning, marital functioning or financial functioning.

That which characterizes them is a burden of anxiety. This is not the neurotic-anxious quality of Type II that permeates all the

areas of functioning. It has more reality in it. Much of it is anxiety about community conformity, about work, about school progress of children. They are over-anxious about personal and familial acceptability, too concerned about meeting the standards which they have acquired or which the community presents. Many of these families live in what some would call slum areas and they have a pervading fear that their children will be drawn into the delinquency common in their neighborhoods.

Some of the anxiety is inherent in the adults, stemming from characters that are infantile or immature, inhibited, insecure, tense and anxious to the point of being neurotic. Low self-esteem is common.

With some there are hold-over attitudes resulting from the family of origin or from clashes of culture. In some it stems from lack of complementarity in marriage, in a few from pronounced mismating.

This anxiety state produces weakness and ineffectiveness that reveals itself mainly in the child-rearing function. There is ignorance of, inconsistency and uncertainty in child-rearing methods. They are unable to "give" to their children. There is too little respect for their needs and too much expectation of performance, or fear that performance will not conform to requirements. Yet they are "working at" the task of child rearing with some concern.

In consequence the children have repressed personal identity. They do not feel on firm ground, hence the appearance of symptoms such as eating problems, bed wetting, thumb sucking, being ill when faced with school requirements. They tend to be emotionally handicapped, immature, hypersensitive, timid. Some are withdrawn and avoid competition. They are sometimes "too good", fear disapproval of parents

and teachers. Some are slow learners. These children are in danger of becoming immature or depressive or neurotic personalities.

Type IB - Character Defects

There is a considerable degree of cohesiveness in these families but a danger of disorganization that does not appear in Type IA. The two instances of broken families in the control group were in this group. What characterizes this group is character disorder in one of the adults, sometimes in both. The most common type of disorder is depressed-dependent. Some are inflexible, narcissistic, demanding. Some are "worry warts", with a fear of not being personnlly "good enough". Hard drinking and severe mental states are some of the manifestations.

As might be expected, the effects on the marital and child-rearing function are more pronounced than in Type IA. There are instances of severe mismating and neurotic marriages. Half of the families in this group had severe marital conflict. The others appear to have complementarity.

The defects do not show up so much in relation to the outside world. Community relationships are not a serious problem. Financial functioning is fair, though there is some disagreement about income and household management.

Rigid, restrictive, authoritarian attitudes characterize the child-rearing function. These defective adult characters are emotionally destructive to their children by being erratic, unreasonable, exhibiting rage and sometimes scapegoating one of the siblings. There is respect for acceptable standards of behavior, but "parenting"

appears to be motivated by need to fulfill the adult personal needs or requirements of status, role or conscience rather than love. However, there is very limited recognition of the needs of the child for stimuli to growth and little provision for variety of interests.

The main problem so far as the children are concerned is that they are emotionally upset as a result of exposure to so much marital conflict. These distorted adult personalities are poor objects of identification. They may grow up to be like them or develop protest symptoms. School problems are common; adjustment to teacher, conflict, learning problems, under-achievers. Stuttering, bedwetting, sneakiness, secretive hostility are found.

Only four children out of all the families in this group were more than thirteen years old. It is a matter of conjecture whether the adolescent years will bring acting-out, delinquency, to these families or rebellion, emancipation or distorted personalities. Much may depend on how they are dealt with in school.

The question arises whether this type should be regarded as more or less "normal" or belongs with the distinctly pathological categories. The problems are apparent, under the scrutiny of an astute social worker. Yet the total family assessment for over one-third was "No significant problems". For the rest the assessment was "Moderate problems" and in almost all it was the problem of one of the partners or in only one of the areas of function.

Everyone knows of families where one parent has defects of character, or where there are marital disagreements, or where a parent is rigid, authoritarian or cantankerous. These are still not regarded as pathological families.

These Type IB families may well be regarded as normal by their community. They are not cases with the social adjustment agencies. They are characterized by attempts to cope with their problem. The stable partners show pronounced effort to adjust to the troublesome partner. One parent often is obviously trying to ameliorate the effects on the children of the other's unwise parenting.

These are families who would benefit from every force that strengthens family life in greater happiness and more assurance of healthy emotional development for the children.

V. THE EARLY IDENTIFICATION PROCESS

Through the early identification process the school administration and the community service agencies, in partnership, have the opportunity for positive intervention with regard to the social and behavior problems which are of concern to them. They gain helpful epidemiological knowledge of the extent and characteristics of the problems. They identify specific families and children, many of whom, it is reasonable to assume, will present social problems with which the community agencies must deal. They discover the children whose classroom behavior may impede educational progress.

This process is not to be confused with attempts at prediction of delinquency, with their danger of isolation and stigmatizing. Properly conducted, the identification process need not stigmatize anyone. It does identify the children with whose behavior school personnel must struggle. There are probably potential truants, drop-outs, delinquents or mentally ill cases among those identified. Primarily, it identifies a considerable number of families who now need or eventually will need the help, support and perhaps therapeutic treatment of the community's services. It marks out a target group upon whom should be especially focussed the public health, mental health, family life education, guidance, casework and psychiatric services that are available. It is based on the principle that these "helping services" should seek out those who need them, make them aware of their need, desirous of help, and render the service "to each according to his need".

Thus a partnership can be developed between educational personnel and the community provided resources, not as attack upon pathology, but as a positive program of constructive effort at child development and

strengthening of family capacity and family life.

The process involves a series of steps:

1. Identification: Screening with the Behavior Rating Scale. The Behavior Rating Scale is administered by the teacher when she has known the children for at least a semester. Someone from the school administration calculates the scores, ranks the children and keeps the records.

The Scale should be administered when the child is first in school. If administered to him in successive grades it could be a helpful part of his record and likewise one possible indicator of progress or lack of it in whatever is being done about him and his family.

The screening process is most applicable in the early grades, up to fifth grade, before the usual age when truancy or delinquency tends to occur.

The research indicates that the top twenty-five percent of the class, those with the highest (most unfavorable) scores should be considered as the group for the further diagnostic steps, or at least for the central administration key list of "potential" families. The number that can be subjected to the diagnostic steps and the provision of required services will depend on the resources of each community.

2. Initial Intervention. Initial intervention occurs when the family of an identified child is first contacted. This initial contact is a most important step in the process to follow. It is at this point that the school principal, school nurse, school psychologist, teacher, social worker, child welfare and attendance worker, mental health consultant, and school counselor need to meet, to understand their respective roles in relation to each other, and to the family and its members.

Someone, preferably the professionally trained social worker or school psychologist, needs to coordinate the efforts of those concerned.

3. Psychological Evaluation. School psychologists will make a diagnosis of each high-ranking child in terms of intellectual level, achievement, special handicaps, personality, type of behavior, and classify the type and degree of emotional disturbance. This step will be pointed at a judgment about what, if anything, in the school setting is contributing to the emotional condition, and what the educational system might do about it.

In California, parent permission is necessary by law before a psychological evaluation may be carried out. This step may have to be deferred until such time as the caseworker has developed sufficient rapport with the family to gain their confidence.

4. Family Diagnostic Study. A qualified professional caseworker should make a diagnostic study of the families of these children. This should be directed at making a judgment as to the extent to which the family situation and interrelationships have a bearing on the child's emotional condition, as well as uncovering the problems in the family calling for help and treatment. The families should be classified in accordance with the diagnostic factors described herein.

If there are no qualified family caseworkers in the schools, arrangements should be sought with Departments of Welfare, Mental Health Services or private Family Service Agencies for this service. These agencies and the Juvenile Court are the ones who can eventually expect to find many of these families in their work-load. If they are genuinely interested in preventive intervention they should be able to organize, probably through the Council of Social Agencies, their participation in this partnership.

Quite a few of these families, as our findings show, are already in the agencies' active work-load or have been known to their services.

It is important that, no matter who furnishes the casework diagnostic service, the caseworker's entree to these families be as an authorized agent of the school administration to extend to the family help with regard to the classroom behavior problem with which they and the school must be concerned.

5. School Planning for Better Adjustment. With the family and child diagnostic data in hand, the psychological evaluation, the educational information, and the A>M<L factors, the persons making the diagnoses and the appropriate school personnel can make a joint judgment as to efforts the school might make through special placement, mental health consultation to teachers, guidance or any other school system resources, to deal with the child's behavior symptoms.

It will be necessary to decide whether conferencing or consultation with the parents is indicated and who should provide it, i.e., teacher, guidance worker, the caseworker or a mental health consultant.

6. Referral for Community Services. A similar process must take place to make a judgment whether the facts indicate the need for treatment service by some community agency. There will be families with obvious need for family casework treatment. The experiences of the Community Research Associates Disordered Behavior Project[1] indicates that this is all that will be required in the majority of cases. Some extreme cases will appear to call for authoritative intervention by a protective service or the Juvenile Court. In a few instances there is clear indication of the need for mental health treatment services for the child or a member of the family.

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[1]Community Research Associates: Op. cit.

Some families will be active cases with community agencies. This will involve sharing diagnostic data and all information that will assist in bringing the agency into partnership with the school with regard to the particular family.

What is discussed here is not a matter of the routine referral of a family to a community agency, a practice all too common. Most families will cooperate with a representative of the school, but many will resist the idea of becoming "clients" of an agency. It will be necessary for the caseworker who made the diagnostic study to establish rapport with the family, bring it to an awareness of its problems and to a readiness to accept skilled help in their solution. It is this type of "reaching out" to the family, as demonstrated in the St. Paul (Minn.) Family Centered Project,[12] that will bring the family to the stage of sufficient understanding, self-esteem and initiative where it will seek help and be a fully participating client in an agency treatment effort. When a family is at this stage the caseworker will assist in securing the service.

The fact must be accepted that some families are so hostile as to be unreachable, so that little or nothing can be done until the inevitable truancy or delinquency involves official action.

7. Coordination of School Services. As was indicated earlier, we are discussing a positive intervention program. There are certain services in schools other than instruction that are applied or are available to the total school population. These should be focussed with special attention,

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[12]Community Research Associates (N.Y.): "The Family Centered Project in St. Paul" Social Casework, October, 1956.

in terms of the diagnostic data, on the target group of children and families. By means of a key index they should be flagged for maximum attention by school nursing, medical, dental, psychological and guidance services. Even the Parent Teacher Association might be enabled to make special efforts to bring these families into its activities, always on the basis that they warrant special encouragement and acceptance.

By administrative attention, through staff conference and exchange of information a team approach should be developed with joint goals, mutual understanding and a common intent to bolster and strengthen the family life and family capacity to cope with problems.

8. Important Implications of the Process. Clinical experience tells us that child behavior problems present a spectrum that ranges from simple reactions to something in the school setting, through reactions to family crises or faulty parenting, all the way to inevitable delinquency or to mental illness. The processes described above make it possible to sort out the children for appropriate treatment. Some children can be left alone because their condition is such that it will pass away of itself. Some will need only more understanding from the teacher, some need only a different classroom setting. In some the condition is temporary, to pass when a temporary family crisis subsides. Some will require no school action, provided their families get the required consultation or treatment. Some more serious cases will need psychological or psychiatric help. Extreme cases will call for special day school or residential treatment because psychiatric diagnosis will reveal them to be genuinely emotionally disturbed children. Thus we can arrive at a true diagnostic category of "emotionally disturbed" children, removing the stigma of that term from children who do not deserve it and allaying some of the current hysteria about "emotional disturbance".

Similarly, the spectrum of family pathology may range from families under temporary external stress or crises such as severe illness, death, unemployment, separation, through basic parental inadequacy and family disorganization, to hostile, anti-social families producing a generation-to-generation sequence of problems. Some families are anxiety-ridden about educational achievement and can be helped by sympathetic consultation from school personnel. Some may need a mental health consultant's help for better understanding and insight. As was indicated earlier there will be some families requiring the services of social adjustment agencies, family case-work, protective services and mental health services.

Heretofore we have not known how the spectrum breaks down in terms of the relative proportions of children and families requiring the different treatment approaches and services, and how they divide between school and community services. When an adequate sample has been put through the processes described above we will have the answers. Then, for the first time, sound community planning can take place with reference to distribution of responsibility, allocation of professional personnel and provision of adequate financing.

VI. THE PLACE OF THE COMMUNITY SOCIAL ADJUSTMENT SERVICES IN THE PROGRAM

As was indicated in the Introduction, the community-provided social adjustment services for maladjustment and dependency have, traditionally, depended on having the problem brought to them. The private casework services, clinics and public welfare departments await the client's application. The protective services await complaints from interested parties that children are neglected. The judicial agencies act when issues are brought before them involving infraction of the laws.

There has long been talk of prevention of social problems. Some mass efforts have been made, based upon unproven assumptions, such as the notion that provision of recreational opportunities prevents delinquency. But the social work field has had no proven methods of prevention as has the public health field in sanitation and immunization from disease. These are termed "primary" prevention methods, preventing the onset of the disease.

During the past decade there has been increasing interest in what public health technicians call "secondary prevention", namely, efforts to control or reduce the effects of the disease after its onset. Just now the most significant development is the announced policy of the Federal Department of Health, Education and Welfare to press for efforts at "rehabilitation" of families on public assistance.

Competent social caseworkers and probation officers have, of course, tried to prevent the recurrence of the pathology with which they are dealing. But the fundamental difficulty is that they do not get most of their cases until the pathology is well-advanced and the prognosis for successful treatment less favorable. It is a common trait of human nature to refuse to

recognize symptoms of trouble and hesitate to seek help, revealing the trouble, until the symptoms become too evident or unbearable. The individual who comes to the point of law violation is presenting the end result of a pattern of pathology. Furthermore, until recently, there has been a tendency to treat the symptoms in the individual rather than deal with the underlying causes in the family. There has been plenty of awareness, from clinical experience, that pathology in early stages is more easily and successfully dealt with. There is plenty of frustration about advanced cases, so much so that some private agencies resist taking them on for treatment. But the social worker has had no way to surmount this difficulty. The social work field has not been geared for case-finding. Indeed, there has been much philosophical resistance to invading the privacy of individuals. Casework practices often have shied away from the resistant, "uncooperative" family and the complex difficulties of the multi-problem family.

To be sure, casework agencies, clinics, probation departments and public welfare departments have been so overburdened with the cases that naturally arrived at their doors that there is little incentive to think about case-finding. There is often awareness that the problems with which they deal are the result of a social heritage, a generation-to-generation sequence of producing problems, and a fear that their efforts are sometimes not preventing a recurrence in this and the next generation.

However, aside from heavy case loads and limited finances, the basic handicap of the social adjustment field is that, unlike the public health field, it has no case-finding techniques, like the X-ray picture for tuberculosis, blood test and similar diagnostic methods.

The early identification process described above is a beginning attempt to supply a technique for case-finding. Success in such an endeavor will

depend on how well the community's social adjustment services organize themselves in relation to the schools and the process. Heretofore, the schools and the agencies have tended, largely, to go their own separate ways.

An article in the January, 1962, Journal of the National Education Association reports 1,200 members of the School Social Work Section of the National Association of Social Workers, and cites Chicago as having 230 school social workers. Such workers, properly, devote themselves to the behavior and social problems which come to the attention of school personnel. If they are well-qualified caseworkers they endeavor to bring into play the community agencies appropriate to the needs of their cases.

The social agencies, particularly the probation services, seek out the schools in relation to the children in their cases. Some private family service agencies have made special efforts at a relationship with school personnel in the interests of case referral.

The result of all this is varying degrees of cooperation. The writer, from community survey experience, is aware that this has ranged from hostility and mutual criticism to fruitful cooperation and mutual understanding. The point is, however, that their several efforts have been directed at particular cases that have fallen into their several jurisdictions, each seeking the help or demanding the cooperation of the other. There has been no concerted attack upon the basic core of families who present most of the trouble with which both have to deal.

To be sure, until recently social agencies were not aware of this group, though some suspected its existence. But now the evidence is in and there is widespread interest in the "hard core", multi-problem group. There is justification for community organization efforts to formulate a joint

program of attack, trying out this early identification process as its starting point.

Real obstacles exist in shortages of personnel and financial resources. Agencies are over-burdened with their current case loads. For the time being this is an added burden. Not entirely so, since an appreciable number of these families are in the current loads. But the family diagnostic screening operation of the process is a plus factor, calling for the assignment of skilled caseworkers.

However, a joint effort by all related agencies can make an experiment possible. To secure the epidemiological data, to learn how the spectrum of family and child trouble breaks up in terms of required agency function, it is important to provide total coverage of the screening and diagnostic processes for an area, no matter how small; one school, one census tract, one distinct neighborhood. Naturally, it would be desirable to coordinate and focus all possible helping services and constructive forces on that area and to provide all possible treatment.

The research connotations here should appeal to Foundations and agencies interested in research. The increased resources coming to be available to public welfare departments for service functions should be a factor. The mental health implications of such an operation are great, the delinquency prevention possibilities are definite, and these should appeal to certain sources of funds.

In its simplest form this is a project that could be carried out by joint action of one school administrator and one family service agency, granted certain resources. But to have its full impact on the community as a prevention movement it is a matter that calls for organization of the maximum available resources by the local Council of Social Agencies. In

the past the working relationships between schools and agencies, betwee. private and public agencies, have often left much to be desired. Here is one area of mutual concern, the same group of families, that should make it possible for them to come more readily together into a joint partnership.

The function of social diagnosis and provision of appropriate treatment services belongs to the social adjustment agencies. The responsibility for case-finding of those who require this service also lies with them. It would seem logical that the program provide that these agencies supply the skilled family caseworkers for the diagnostic and referral process. This would make for the desired continuity if family casework treatment is indicated. If the school has its own social workers there still remains for them the consultation service for families that do not require outside agency services, as well as the liaison function between schools and agencies.

The private family service agencies come to the fore here. The Child Welfare Services of public welfare departments have, in theory at least, a generalized casework function. There is, increasingly, talk in the psychiatric clinic field of family casework. It is conceivable that the early identification and prevention program could deploy all these possible resources. The essence of the matter is that social diagnosis and the provision of, or arranging for, required treatment should be performed by a trained caseworker, qualified to make a family diagnosis and provide family casework treatment.

VII. SUMMARY

1. The results of the study would seem to indicate that the classroom teacher, with the aid of a reliable Behavior Rating Scale, is able to identify a very significant proportion of young children whose school behavior reflects families with problems. Eighty percent of the experimental families were identified by Behavior Rating Scales I and II.

2. Three FACTORS known as A> (Aggressive-Outgoing), M< (Internalizing-Moody), L (Learning) were identified through the factor analysis. With additional analysis, the items contributing to these factors may be further refined.

3. The 11-item A>M<L Behavior Rating Scale is suggested as a reliable screening technique for the early identification of behavior problem children and multi-problem families. The Kuder-Richardson 21 reliability formula, when applied to the total population under study, shows an R of .7396 for Behavior Rating Scale I and an R of .9103 for Behavior Rating Scale II.

4. Further research is indicated in order to evaluate the family early identification process as suggested in this study.

A P P E N D I X

Pupil _____ District _____

Birth Date _____ Grade _____ School _____

Date of Rating _____ Teacher _____

BEHAVIOR RATING SCALE I*

PLEASE RATE THE PUPIL'S BEHAVIOR AS YOU HAVE OBSERVED AND EXPERIENCED IT This Pupil —	Seldom or Never (1)	Not Very Often (2)	Often (3)	Most of the Time (4)	All of the Time (5)	
1. Gets into fights or quarrels with other pupils	☐	☐	☐	☐	☐	1.
2. Has to be coaxed or forced to work or play with other pupils	☐	☐	☐	☐	☐	2.
3. Has difficulty learning	☐	☐	☐	☐	☐	3.
4. Is interested in activities which he can do himself	☐	☐	☐	☐	☐	4.
5. Makes unusual or inappropriate responses during normal school activities	☐	☐	☐	☐	☐	5.
6. Behaves in ways which are dangerous to self or others	☐	☐	☐	☐	☐	6.
7. Is unhappy or depressed	☐	☐	☐	☐	☐	7.
8. Becomes sick when faced with a difficult school problem or situation	☐	☐	☐	☐	☐	8.

	Much Above Average	Above Average	Average	Below Average	Much Below Average	
9. Intellectual potential with respect to present class is	☐	☐	☐	☐	☐	9.

	Among the Best	Average	Among the Poorest	
10. Emotional adjustment with respect to present class is	☐	☐	☐	10.

	Yes	No	
11. Is one of the two most emotionally disturbed pupils in this class	☐	☐	11.
12. Is one of the two pupils with the best mental health in the class	☐	☐	12.

(5-24-60)

13. Total Score: Items 1-8 _____ 13.

*Revised State Scale

Pupil _____

Sex _____ Grade _____

Teacher _____

Please check (✓) the appropriate rating for each item.

BEHAVIOR RATING SCALE II*

This Pupil —	Seldom or Never (1)	Not Very Often (2)	Often (3)	Most of the Time (4)	All of the Time (5)	
14. Is very assertive in his (her) behavior toward other children	☐	☐	☐	☐	☐	14.
15. Cannot control his desires	☐	☐	☐	☐	☐	15.
16. Is very restless	☐	☐	☐	☐	☐	16.
17. Enjoys disrupting class discipline	☐	☐	☐	☐	☐	17.
18. Starts fights easily	☐	☐	☐	☐	☐	18.
19. Is very obstinate	☐	☐	☐	☐	☐	19.
20. Is overly sensitive to criticism	☐	☐	☐	☐	☐	20.
21. Is very impulsive	☐	☐	☐	☐	☐	21.
22. Can be very moody	☐	☐	☐	☐	☐	22.
23. Responds readily to negative suggestions	☐	☐	☐	☐	☐	23.

24. Total Score _____ 24.

(5-24-60)

*Mikita Scale

TABLE 6. CORRELATION TABLE FOR ITEMS ON BEHAVIOR RATING SCALE I AND BEHAVIOR RATING SCALE II
GRAND TOTAL OF ALL THREE GROUPS - EXPERIMENTAL, CONTROL, RESIDUAL

N = 2872

	Behavior Rating Scale I												Total Score		Behavior Rating Scale II								Total Score			
Items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	$\bar{X}$	s
1		44	32	-07	58	71	47	29	23	53	-32	19	75	73	65	63	71	84	68	34	70	50	24	79	1.853	1.008
2			46	-12	46	41	55	44	34	52	-31	18	72	29	40	42	41	41	49	45	42	54	19	53	1.643	.929
3				-24	45	32	39	31	76	48	-21	23	62	19	35	45	32	30	31	30	32	33	13	40	2.195	1.146
4					-13	-09	-11	-11	-22	-20	-08	08	-08	-00	-06	-12	-10	-07	-08	-04	-08	-09	03	-08	3.050	1.166
5						61	41	32	31	51	-33	16	74	46	59	61	65	56	55	33	63	46	22	67	1.635	.933
6							44	30	21	47	-33	14	73	55	57	57	67	71	60	29	63	43	27	70	1.449	.799
7								56	27	53	-35	19	71	33	41	41	40	42	49	50	43	66	18	55	1.582	.816
8									21	37	-24	14	57	21	27	31	29	28	34	42	30	47	13	39	1.283	.618
9										46	-15	28	44	11	25	32	22	22	21	19	20	22	08	26	2.861	1.025
10											-41	35	63	38	51	55	52	50	52	38	51	54	16	60	1.890	.684
11												01	-39	-25	-32	-31	-34	-32	-34	-23	-35	-31	-10	-38	1.923	.271
12													23	12	18	21	16	17	17	16	15	19	07	21	1.903	.301
13														55	68	66	67	69	67	50	67	64	27	78	14.679	4.488
14															65	62	66	72	63	30	69	44	29	79	2.034	1.094
15																72	68	65	62	36	73	50	29	82	1.977	1.096
16																	71	62	61	34	74	50	24	80	2.115	1.122
17																		74	73	32	74	50	26	83	1.706	1.010
18																			72	35	72	51	27	83	1.708	.994
19																				45	70	65	24	83	1.649	.975
20																					42	62	17	57	1.965	1.047
21																						55	28	87	1.868	1.076
22																							22	72	1.773	.984
23																								45	2.252	1.320
24																									19.012	8.004

TABLE 7

FACTOR ANALYSIS: NORMAL VARIMAX LOADINGS FOR 24 ITEMS ON 4 FACTORS (AFTER ROTATION)
BEHAVIOR RATING SCALE I : BEHAVIOR RATING SCALE II

N = 2872

	Items	Communality	Factors I (A>) Aggressive-Outgoing	II (M<) Internalizing-Moody	III (L) Learning	IV
BRS I	1	.754249	.837729	.209025	.076924	-.053375
	2	.587487	.319974	.643887	.244309	-.104041
	3	.763183	.235832	.320492	.742137	-.232556
	4	.509146	-.024358	.014606	-.243736	.670024
	5	.593596	.657105	.260432	.237857	-.193410
	6	.626939	.749922	.210153	.078181	-.119495
	7	.708499	.309758	.771476	.092393	-.093999
	8	.560198	.144305	.727004	.061002	-.084366
	9	.772903	.131125	.184275	.824355	-.205400
	10	.614682	.469409	.434577	.393318	-.225346
	11	.463329	-.318016	-.343301	.122979	.478764
	12	.459155	.128243	.114637	.588209	.289097
Total Score BRS I (Items 1-8)	13	.862563	.652389	.598535	.280430	-.008117
BRS II	14	.714473	.837733	.074134	-.048132	.069740
	15	.685310	.794597	.187262	.135672	-.021239
	16	.694377	.768033	.185750	.245723	-.098073
	17	.773370	.853801	.157308	.080192	-.114965
	18	.774411	.859891	.176628	.047211	-.039654
	19	.701580	.751056	.367259	.011304	-.049878
	20	.581235	.260518	.706777	.022792	.115373
	21	.769186	.842994	.232335	.040479	-.054111
	22	.705493	.462265	.700858	.019230	.015204
	23	.342397	.360080	.117636	.110825	.431995
Total Score BRS II (Items 14-23)	24	.958401	.897959	.376379	.091488	.045150

TRACE = 15.976169 (11 ROTATIONS WERE ATTEMPTED ON THE 6 PAIRS OF COLUMNS)

TABLE 8

POSITION OF CHILD IN FAMILY AS IT RELATES TO HIS RATING ON BEHAVIOR RATING SCALE II.

N= 100 Children Experimental Group (X)
100 Children Control Group (C)

Position of Child in Family	Ratings on Behavior Rating Scale II						Total	
	Group A (Rank 1,2,3)		Group B (Rank 4-8)		Group C (Rank 9+)			
	X	C	X	C	X	C	X	C
11	1	-	-	-	-	-	1	-
10	-	-	-	-	1	1	1	1
9	-	-	3	-	-	-	3	-
8	-	-	1	-	4	-	5	-
7	-	-	2	-	2	1	4	1
6	1	-	2	-	4	1	7	1
5	3	-	2	1	8	2	13	3
4	7	-	9	-	7	7	23	7
3	10	-	5	1	4	21	19	22
2	7	-	4	4	6	31	17	35
1	3	-	2	3	2	27	7	30
Total	32	-	30	9	38	91	100	100

Findings are based on ratings on BRS II inasmuch as this was the scale used in determining the selection of the Control Group.

TABLE 9

THE INCIDENCE OF COUNTY AGENCY SERVICE TO EXPERIMENTAL FAMILIES AS IT RELATES TO THE RATINGS OF THEIR CHILDREN ON BEHAVIOR RATING SCALE II.

N = number of experimental children

Agency Service	Ratings on Behavior Rating Scale II						Total	
	Group A (Rank 1,2,3)		Group B (Rank 4-8)		Group C (Rank 9-etc.)			
	N	% of Total N in Each Service	N	% of Total N in Each Service	N	% of Total N in Each Service	N	% in Each Service
Combination: (more than one service)	5	29%	7	41%	5	29%	17	17%
School Social Services	2	22%	4	44%	3	33%	9	9%
Social Service Only	-	-	1	33%	2	66%	3	3%
Wardship Probation Supervision	4	20%	4	20%	12	60%	20	20%
Financial Assistance	21	41%	13	25%	17	33%	51	51%
Total N	32		29		39		100	100%

Findings are based on ratings on BRS II inasmuch as this was the scale used in determining the selection of the Control Group.

TABLE 10

THE INCIDENCE OF FAMILY TYPE CLASSIFICATION* FOR EXPERIMENTAL AND CONTROL FAMILIES AS IT RELATES TO THE RATINGS OF THEIR CHILDREN ON BEHAVIOR RATING SCALE II.

N = number of children

Family Type	Ratings on Behavior Rating Scale II												Total			
	Group A (Rank 1,2,3)				Group B (Rank 4-8)				Group C (Rank 9-etc.)							
	X		C		X		C		X		C		X		C	
	N	% of Total N per Type	N	% of Total N per Type	N	% of Total N per Type	N	% of Total N per Type	N	% of Total N per Type	N	% of Total N per Type	N	% of Total N	N	% of Total N
I Normal with External Problems	-	-	-	-	-	-	7	12%	-	-	52	88%	-	-	59	59%
IA Anxiety • Burdened	-	-	-	-	-	-	2	8%	-	-	23	92%	-	-	25	25%
IB Character Defect	-	-	-	-	-	-	2	13%	-	-	14	87%	-	-	16	16%
II Neurotic Anxious	4	25%	-	-	9	56%	-	-	3	19%	-	-	16	16%	-	-
III Socially Ineffective	19	33%	-	-	13	23%	-	-	24	42%	-	-	56	56%	-	-
IV Socially Inadequate	2	14%	-	-	6	42%	-	-	6	42%	-	-	14	14%	-	-
V Non-Conforming, Hostile	7	64%	-	-	-	-	-	-	4	36%	-	-	11	11%	-	-
Unclassified	-	-	-	-	1	33%	-	-	2	66%	-	-	3	3%	-	-
Total	32	-	-	-	29	-	11	-	39	-	89	-	100	100%	100	100%

Findings are based on ratings on BRS II inasmuch as this was the scale used in determining the selection of the Control Group.

*See Interview Schedule for description of Family Types. Appendix p. 83.

Pupil _____

Birth Date _____ Sex _____

Date of Rating _____

District _____

School _____

Grade _____

Teacher _____ _____

A>M<L BEHAVIOR RATING SCALE

PLEASE RATE THIS PUPIL'S BEHAVIOR AS YOU HAVE OBSERVED AND EXPERIENCED IT This Pupil —	Seldom or Never (1)	Not Very Often (2)	Often (3)	Most of the Time (4)	All of the Time (5)	
(A) 1. Gets into fights or quarrels with other pupils	☐	☐	☐	☐	☐	1.
(M) 2. Has to be coaxed or forced to work or play with other pupils	☐	☐	☐	☐	☐	2.
(A) 3. Is very restless	☐	☐	☐	☐	☐	3.
(M) 4. Is unhappy or depressed	☐	☐	☐	☐	☐	4.
(A) 5. Enjoys disrupting class discipline	☐	☐	☐	☐	☐	5.
(M) 6. Becomes sick when faced with a difficult school problem or situation	☐	☐	☐	☐	☐	6.
(A) 7. Is very obstinate	☐	☐	☐	☐	☐	7.
(M) 8. Is overly sensitive to criticism	☐	☐	☐	☐	☐	8.
(A) 9. Is very impulsive	☐	☐	☐	☐	☐	9.
(M) 10. Can be very moody	☐	☐	☐	☐	☐	10.
(L) 11. Has difficulty learning	☐	☐	☐	☐	☐	11.

A> Score _____

M< Score _____

L Score _____

Total _____

(1962): Office of the San Mateo County Superintendent of Schools
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